Brockville General Hospital

BONE DENSITY REQUISITION

PLEASE FAX COMPLETED REQ/QUESTIONNAIRE TO (855) 564-1844

As of August 2025

PATIENT INFORMATION

Last Name	First Name	Date of Birth	YYYY	MM	DD

Address	City	Postal Code

Phone	E-mail Address	Health Card Number	Ver Code

Clinical information

Patient's height? _____ feet _____ inches Weight? _____ lbs

1. Previous Bone Density exam here or elsewhere in Ontario? ☐ **Y** ☐ **N**
   If yes when? _____
2. Surgery on your lower spine or your hips? ☐ **Y** ☐ **N**
3. Nuclear medicine test or x-ray/CT with contrast (i.e. barium) in the last 2 weeks? ☐ **Y** ☐ **N**
4. Do you smoke, or have you ever smoked? ☐ **Y** ☐ **N**
   If yes, for how long? _____
5. Do you take calcium supplements (including tums)? ☐ **Y** ☐ **N**
6. Are you taking or have you ever taken (Please check any that apply)
   - ☐ FOSAMAX - How long? _____ ☐ DIDROCAL - How long? _____
   - ☐ EVISTA - How long? _____ ☐ ACTONEL - How long? _____
   - ☐ PROLIA - How long? _____ ☐ ACLASTA - How long? _____
7. Have you been on Prednisone or steroids for more than 3 months in 1 year? ☐ **Y** ☐ **N**
   If yes, is the amount you took 2.5 mg or more in 1 day? ☐ **Y** ☐ **N**
8. Do you take thyroid medication? ☐ **Y** ☐ **N**
   If yes, for how long? _____
9. Are you taking medications for rheumatoid arthritis? ☐ **Y** ☐ **N**
10. Has anyone in your family had osteoporosis? ☐ **Y** ☐ **N**
11. Have you had any fractured bones as an adult? ☐ **Y** ☐ **N**
12. Have you ever had cancer? ☐ **Y** ☐ **N**
13. Have you had a hysterectomy or ovaries removed? ☐ **Y** ☐ **N**
    If yes when? _____
    Please circle what applies:
    ☐ **Uterus ONLY** ☐ **Ovaries ONLY** ☐ **Uterus AND Ovaries**
14. Are you post-menopausal (periods have stopped)? ☐ **Y** ☐ **N**
    If yes when? _____
15. Are you taking or have you ever taken hormone replacement therapy (HRT)? ☐ **Y** ☐ **N**
    If yes, what is or was the dose? _____
16. Are you pregnant? ☐ **Y** ☐ **N**

CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): _____/____/____

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number
Clinician Signature	**Clinician Phone Number**

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number